

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03870

3867

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Bloomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural	
3. NAME OF DECEASED (Type or print) Ethel		First Annie	Middle Andrews
4. DATE OF DEATH April 12 1957		Last Month Day Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 26, 1889		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Sussex Co., Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Washington Reeves		14. MOTHER'S MAIDEN NAME Annie (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-12-0160	17. INFORMANT Address Charles E. Andrews, Federalsburg, Md., R.F.D.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 8 days.	
DUE TO (b) Generalized arteriosclerosis (c) Cerebral hemorrhage		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 10</u> , 1949, to <u>Apr. 12</u> , 1957, that I last saw the deceased alive on <u>Apr. 13</u> , 1957, and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Federalsburg, Md.</u> DATE SIGNED	
ACTUAL SIGNATURE <u>W. E. Lennon</u>		M.D.	
PHYSICIAN'S NAME (Type) W. E. Lennon, M.D.		Federalburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 15, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery
22d. LOCATION (City, town, or county) Federalsburg, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE Apr. 15, 1957	24b. REGISTRAR'S SIGNATURE Margret H. Frampton

01. JUNIO 1948 - ITALIA RICONOSCE IL DIAVOLI DELL'AVVOCATO

## BUREAU K-5

APR 22 1957

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03871

Reg. Dist. No.

3868

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Ridgely			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garland Lake				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Claudell		First Eugene	Middle Blades	4. DATE OF DEATH April 14 1957	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1929	9. AGE (In years last birthday) 27 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Staff Sgt. Air Force		10b. KIND OF BUSINESS OR INDUSTRY U. S. Air Force		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. Vernon Blades		14. MOTHER'S MAIDEN NAME Della Knox					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT W. Vernon Blades, Ridgely, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)		Drunk driving - accidental Concussion of Brain Automobile accident		INTERVAL BETWEEN ONSET AND DEATH few hours before death	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident - Struck an Abutment + into Park		20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:26 p. m. 4-14 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) Ridgeley, Caroline, Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE DAWSON D. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-17-57			
EXAMINER'S NAME (Type) DAWSON D. George							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 18, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 4/17/57		24b. REGISTRAR'S SIGNATURE Dawson D. George	

RE-PROMULGATE AN ACT TO TRANSFER THE STATE OF HAWAII FROM  
NTABO TO ESTABLISHED BIRMANIA (POLITICAL)

1951 3. 25

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3859

## CERTIFICATE OF DEATH

03872

Reg. Dist. No. 47

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 20x12 Rural Cordova	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First FRANK	Middle 	Lost BOYLES	4. DATE OF DEATH Month APR. 17	Day 1957	Year 
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5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG 1, 1892	9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	12. IF UNDER 24 HRS. Hours 	13. IF UNDER 24 HRS. Min. 
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm owner	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME William C. Boyles	14. MOTHER'S MAIDEN NAME Rhoda Brown
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Hershey Harry Denton, fed.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONS AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.			
(b) Metastatic carcinoma of the neck gland			
DUE TO (c) Carcinoma of the left upper lid 2 years			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Diabetes mellitus. Impression of left leg				

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 	Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 	(County)	(State)
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21. I certify that I attended the deceased from <u>March</u> , 19 <u>51</u> , to <u>April</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>April 16</u> , 19 <u>51</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.
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ADDRESS (Street, city or town, state)

ACTUAL SIGNATURE Kurt Leiserer	M.D.	DATE SIGNED 4-19-51
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PHYSICIAN'S NAME (Type) KURT LEISERER	Maryland
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 20, 1951	22c. NAME OF CEMETERY OR CREMATORIAL Greenmount	22d. LOCATION (City, town, or county) Talbot
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23. FUNERAL DIRECTOR'S SIGNATURE Frank Brown, Jr.	ADDRESS Denton, Md.	24a. REC'D BY REGISTRAR DATE 4/20/51	24b. REGISTRAR'S SIGNATURE Wm. O. George
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CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**  
**3870**

03873

Reg. Dist. No. 64

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
 SM 9/55

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near American Corner		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural	
3. NAME OF DECEASED (Type or print) Retha		First Louise	Middle Haynes
4. DATE OF DEATH Month April Day 20 Year 1957		5. SEX Female	
6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 4, 1925		9. AGE (in years last birthday) 32 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Henry Haynes		14. MOTHER'S MAIDEN NAME Bessie Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 220-05-1859	
17. INFORMANT Corenia M. Cook, Preston, Md., R.F.D.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <b>Shock - Multiple Fractures</b> PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 812 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Automobile accident</b> DUE TO (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  <b>Run over by Automobile</b>	
20c. TIME OF INJURY Hour 3 a. m. 14-23-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  <b>Highway</b>		20f. (City or town)  <b>Rural Federalsburg Caroline Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dawson D. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dawson D. George</b>		DATE SIGNED <b>4-23-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23, 1957	
22c. NAME OF CEMETERY OR CEMETORY Harmony Cemetery		22d. LOCATION (City, town, or county) (State) Near Preston, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE 4-23-57		24b. REGISTRAR'S SIGNATURE Margaret H. Frampton	

STATE OF ILLINOIS - EXAMINER'S CERTIFICATE OF BEAVER

BUREAU V. 3

APR 26 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3871

## CERTIFICATE OF DEATH

Reg. Dist. No. 103874

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Henderson</b>		c. LENGTH OF STAY IN 1b <b>65 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Henderson</b>	
d. STREET ADDRESS <b>None</b>		d. STREET ADDRESS <b>None</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Rev. Noble</b>		First <b>N.</b>	Middle <b>Henry</b>
4. DATE OF DEATH <b>4 23 57</b>		Month <b>4</b>	Day <b>23</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>2/16/1892</b>		9. AGE (In years last-birthday) <b>65</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charlie Henry</b>		14. MOTHER'S MAIDEN NAME <b>Ida Lockerman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Rosa J. Henry</b>		Address <b>Henderson, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b>			
DUE TO <b>Cerebral Hemorrhage with hemiplegia</b>			
INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Cardiovascular Renal Disease with</b>			
DUE TO (c) <b>hypertension</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 22, 1957</b> to <b>Apr. 23, 1957</b> , that I last saw the deceased alive on <b>Apr. 23, 1957</b> , and that death occurred at <b>3:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b>			
DATE SIGNED <b>4-25-57</b>			
ACTUAL SIGNATURE <b>Chas. H. Stonesifer</b>			
PHYSICIAN'S NAME (Type) <b>Chas. H. Stonesifer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) <b>Goldsboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaire</b>		ADDRESS <b>Greensboro, Md.</b>	
24a. REC'D BY REGISTRAR <b>4/26/57</b>		24b. REGISTRAR'S SIGNATURE <b>J. C. Smith</b>	

## CERTIFICATE OF DEATH

RECEIVED  
BUREAU

APR 29 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03875

3872

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		c. LENGTH OF STAY IN lb. <i>6</i>		
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>AMANDA</i>	Middle <i>JANE</i>	Last <i>MURRAY</i>	
4. DATE OF DEATH	Month <i>APRIL</i>	Day <i>21</i>	Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APR. 13, 1859</i>	
9. AGE (In years lost or birthday) <i>78 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Samuel [Unknown]</i>	14. MOTHER'S MAIDEN NAME <i>Hester Murray</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i>[Redacted]</i>	17. INFORMANT <i>(Yes) Hester N. Murray, Denton, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerosis</i> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO  (c)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <i>20 yr</i>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year 1955	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>[Redacted]</i>	20f. (City or town) <i>Denton</i>	(County) <i>[Redacted]</i>	(State) <i>[Redacted]</i>	
21. I certify that I attended the deceased from <u>Feb 8</u> , 1955, to <u>April 19</u> , 1957, that I last saw the deceased alive on <u>April 19</u> , 1957, and that death occurred on <u>11:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>[Redacted]</i> DATE SIGNED <i>[Redacted]</i>				
ACTUAL SIGNATURE <i>E. Paul Knotts</i>	M.D.			
PHYSICIAN'S NAME (Type) <i>E. Paul Knotts M.D.</i>	Denton, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Apr. 27, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Springside</i>	22d. LOCATION (City, town, or county) <i>Denton</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeVayle Leonison, Denton, Md.</i>	ADDRESS <i>[Redacted]</i>	24a. REC'D BY REGISTRAR <i>[Redacted]</i>	24b. REGISTRAR'S SIGNATURE <i>Mrs. D. George</i>	
DATE <u>4/26/57</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 380001558-17243H 90 398474000 37472 000 398474

BUREAU V. S.

APR 29 1957

# REFUGEE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08876

3873

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel		c. LENGTH OF STAY IN 1b 10 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Abraham		First J. Note	4. DATE OF DEATH 4 19 1957
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/23/1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Penns.
13. FATHER'S NAME Abraham Note		14. MOTHER'S MAIDEN NAME Eliza Lyster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 194-20-8895	17. INFORMANT Mrs. Joseph McCoy Marydel, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Cerebral Hemorrhage with hemiplegia DUE TO (b) Cardiovascular Renal Disease DUE TO (c) General Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 18, 1957, to April 19, 1957, that I last saw the deceased alive on April 18, 1957, and that death occurred at 6:30AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md.			
ACTUAL SIGNATURE Charles H. Stonesifer PHYSICIAN'S NAME (Type)		DATE SIGNED 4-19-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/57	22c. NAME OF CEMETERY OR CREMATORIUM Fernwood
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire Greensboro, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE 4-28-57
			24b. REGISTRAR'S SIGNATURE C. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87. BROMPTON-PIAZZA DELLA REPUBBLICA 37A/2 00187 ROMA

MAY 6 1957

# РЕГЕЛИВ ЕД

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3874

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

03877

1. PLACE OF DEATH a. COUNTY Caroline			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Federalburg			c. LENGTH OF STAY IN 1b Life					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 Greenridge Road			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg					
3. NAME OF DECEASED (Type or print) Annie			First Elizabeth	Middle Spicer	Last 12			
4. DATE OF DEATH April	Month 12	Day 1957	Year 1957					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1887	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Federalburg, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James H. Davis			14. MOTHER'S MAIDEN NAME Annie V. Wright					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None	17. INFORMANT James O. Spicer, Salisbury, Maryland	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			Carcinoma ch. breast Generalized metastasis			INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		
DUE TO (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Federalburg	(County)	(State)	
21. I certify that I attended the deceased from <u>Oct 1, 1956</u> to <u>4/12, 1957</u> that I last saw the deceased alive on <u>4/12, 1957</u> , and that death occurred at <u>9:40A</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frank M. Anderson, M.D.</u> <u>Federalburg, Md. 4/15/57</u>								
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 16, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery	22d. LOCATION (City, town, or county) Federalburg, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DATE April 15, 1957	24b. REGISTRAR'S SIGNATURE Margaret H. Frampton			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BUREAU V.

APR 22 1957

REFUGEE ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03878

3875

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>		d. STREET ADDRESS <b>Bethlehem</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bethlehem</b>				d. STREET ADDRESS <b>Bethlehem</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Harry</b>	Middle <b>Miller</b>	Last <b>Towers</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>6</b>	Year <b>1957</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>February 7, 1885</b>	9. AGE (In years at birthday) <b>72</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Towers</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Murphy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Lura M. Towers, Preston, Md., R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Cardiac衰弱</b>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Generalized Arteriosclerosis</b>							
DUE TO <b>bad coronary condition</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Right hemiplegia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that I attended the deceased from <b>April 1, 1952</b> to <b>April 16, 1957</b> , that I last saw the deceased alive on <b>April 1, 1957</b> , and that death occurred at <b>8:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Preston, Maryland</b>							
DATE SIGNED <b>—</b>							
ACTUAL SIGNATURE <b>Jacq B. Plummer</b>		M.D.					
PHYSICIAN'S NAME (Type) <b>Harold B. Plummer</b>		Preston, Maryland 11/9/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Junior Order Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Preston, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>4-9-57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Cornelia W. Plummer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAMS STATE DEPARTMENT OF HEALTH—REGISTRY

BUREAU V. S.

APR 11 1957

REGISTRY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, striking the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**3876 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. (13829)

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL RIDGELY</b>		c. LENGTH OF STAY IN lb <b>RURAL RIDGELY</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <b>ELWOOD</b>		4. DATE OF DEATH Month <b>APR.</b> Day <b>7</b> Year <b>1957</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>AUGUST 25, 1914</b>	8. AGE (In years last birthday) <b>42 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chicken</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>JERRY WARREN</b>		14. MOTHER'S MAIDEN NAME <b>MARYIE MATTHEWS</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW II 218070290</b>	17. INFORMANT <b>Jessie Seth Ridgely, husband</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <b>Deceased</b>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Atherosclerosis				
420.1 Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last. <b> </b>		DUE TO (b)  DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b> </b>	20f. (City or town) <b> </b>	(County) <b> </b>	(State) <b> </b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <b>Dawson D. George</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>4/9/57</b>		
EXAMINER'S NAME (Type) <b> </b>	22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 9, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Henry's Farm</b>	22d. LOCATION (City, town, or county) <b>Ridgely, Md.</b>	(State) <b> </b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Virgil Moore &amp; Son, Pottow, Md.</b>	ADDRESS <b> </b>	24a. REC'D BY REGISTRAR <b> </b>	24b. REGISTRAR'S SIGNATURE <b> </b>	DATE <b>4/9/57</b>		

RECEIVED  
FBI BUREAU

APR 11 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3877

Item 6 Film G214 5-7-57 et

## CERTIFICATE OF DEATH

03880 62

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>	
d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret</i>		First <i></i>	Middle <i>Wiley</i>
4. DATE OF DEATH <i>Apr 28 1957</i>		Month <i>Apr</i>	Day <i>28</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec 29, 1874</i>		9. AGE (In years (at birthday) <i>82</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i></i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	Days <i></i>
13. FATHER'S NAME <i>Nathan Corkran</i>		14. MOTHER'S MAIDEN NAME <i>Dre Blodes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mrs Roger Dukes, Denton, Md</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>431X Myocarditis Acute</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Renal suppession</i>		2 days -	
(c) <i>Cystic ovary</i>		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Apr 18 1957</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-18 1957</i> to <i>4-28 1957</i> that I last saw the deceased alive on <i>4-28 1957</i> , and that death occurred at <i>Denton, Md</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Denton, Md</i>			
ACTUAL SIGNATURE <i>Dawson O. George M.D.</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Dawson O. George</i>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 1, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Holts</i>		22d. LOCATION (City, town, or county) <i>Holts Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Virgil Morris Son, Denton</i>		ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>5-1-57</i>
		24b. REGISTRAR'S SIGNATURE <i>Tom O. George</i>	

CERTIFICATE OF DEATH

DEATH

BUREAU V. A.

MAY 3 1957

RECEIVED